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A THEMATIC MODEL OF COPING AND HELP-SEEKING: LIVED EXPERIENCES OF ANXIETY AND EMOTIONAL REGULATION AMONG FLOOD-AFFECTED COMMUNITIES IN PAKISTAN, 2025

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Abstract

Background: Floods are recurrent climate disasters in Pakistan that produce long-lasting psychological burdens which often outlast visible reconstruction. Despite high population exposure, little is known about how affected communities interpret, regulate, and cope with flood-related anxiety within local religious and family systems. **Objective**: To develop a culturally grounded thematic model of anxiety, emotional regulation, coping, and help-seeking among adults affected by the 2025 monsoon floods in Pakistan.

Methods: Using reflexive thematic analysis, semi-structured interviews were conducted with 15 purposively sampled adults (8 women, 7 men; ages 29–56) from Sindh and Punjab approximately one month after flooding. Interviews were transcribed in original languages, translated into English with back-translation checks, and analyzed inductively to generate themes.

Results: Six interlinked themes emerged: Immediate Trauma Response; Persistent Environmental Anxiety; Emotional Regulation in Cultural Context; Coping Strategies; Barriers to Formal Help-Seeking; and Collective Resilience and Post-Traumatic Growth. Participants described acute fear during the flood that conditioned everyday weather cues into chronic hypervigilance and intrusive re-experiencing, expressed through idiomatic and somatic language. Emotional regulation was relational and gendered: suppression preserved family functioning and social reputation, while women used private female networks for disclosure. Religious practices and mosque-based communal support served as primary regulatory resources, but sometimes moralized persistent symptoms, discouraging formal help-seeking. Poverty, travel costs, service scarcity, and reputational stigma created major access barriers. Community-based, faith-integrated supports and mutual aid were important resilience mechanisms.

Conclusions: Flood-related anxiety in Pakistan is an ecological phenomenon shaped by faith, collectivist emotion norms, and structural inequities. Disaster mental-health responses should be embedded in religious and community platforms, decentralized, low-cost, and gender-sensitive to address both psychosocial needs and access barriers. The thematic model offers a culturally attuned foundation for designing hybrid community-faith interventions.

Keywords: flood, mental health, post-flood anxiety, environmental anxiety, religious coping

INTRODUCTION

Climate-induced disasters are among the most urgent public-health threats of the twenty-first century, and their psychological consequences often outlast visible reconstruction (Sharpe & Davison, 2021). Pakistan is exceptionally vulnerable to climate-related flooding: analyses of historical records and government reports identify repeated, large-scale flood events since 1950, with the Federal Flood Commission and subsequent reviews documenting dozens of major floods that have cumulatively caused thousands of deaths and multi-billion-dollar economic losses (Waseem & Rana, 2023; WWF/FFC synthesis, 2025). The 2010 "Super Flood" affected approximately 20 million people and produced widespread agricultural and infrastructure loss (NASA/UN summaries; Waseem & Rana, 2023), while the 2011 and 2014 events again inundated millions and exacted hundreds of lives in Sindh and other provinces. The 2022 monsoon floods represented an unprecedented national catastrophe, affecting an estimated 33 million people and producing direct damages and losses assessed at roughly USD 30 billion (World Bank PDNA, 2022), and the ongoing 2025 monsoon cycle has already caused further deaths, displacement, and infrastructure collapse in districts across Khyber Pakhtunkhwa and Gilgit-Baltistan (World Bank, 2022; news reporting, 2025). This pattern of repetitive events establishes a cumulative experience of exposure to trauma and persistent insecurity that is qualitatively distinct to the single event disasters and increases the vulnerability to mental health problems over time (Lowe et al., 2019; Waseem & Rana, 2023).
Nevertheless, even with the magnitude of exposure, the mental-health system of Pakistan is under-resourced and inequitably allocated, especially in rural and flood-impacted communities (Waite et al., 2017), whereby specialist services are few and primary-care integration is nonexistent (Dayani et al., 2024). Meanwhile, local sensemaking, which is based on Islamic theological and systems, kinship (biradari) ties, and collectivist family and gender roles, has a direct influence on identifying, telling, and addressing distress (Mahmood et al., 2021; Abu-Ras et al., 2024). One of the risks of the Western and individualistic diagnostic framings is that it may distort the phenomenology of post-flood suffering in Pakistani communities, where spiritual explanations (e.g., imtihan/azmaish, taqdeer) and communal supports can take the epistemic centre of coping (Mahmood et al., 2021; Khan et al., 2023). Certain fusion of recurring exposure to climate, structural resource deprivation, and culturally determined clarifying models makes a quality need to develop qualitative and context-specific research that records lived experience of anxiety and emotional regulation post floods and consequently informs culturally consistent interventions that build on indigenous resilience than provide an alienating clinical framework.

LITERATURE REVIEW

Mental-health impacts of floods and cumulative exposure. The frequency of anxiety, depression, and the post-traumatic stress in survivors is always noted to be high in meta-analyses and systematic mappings of flood-related mental health, and the impact frequently lingers months or years after the incident (Rataj et al., 2016; Fernandez et al., 2015). Cumulative exposure amplifies risk in settings of recurring flooding, including the Indus basin in Pakistan, longitudinal and cross-sectional research have shown that every disaster exposure increases the severity of symptoms and functional impairment, and increases the risk of chronic anxiety disorders and abnormal emotional responding (Lowe et al., 2019; Nöthling et al., 2024). Reviews and commentaries that are unique to Pakistan following the 2022 floods reported very high prevalence of clinically significant distress in a variety of community samples, and spot estimates of anxiety, depression and PTSD, frequently higher than the typical post-disaster levels (Yousuf et al., 2023; Waseem & Rana, 2023). Hypervigilance and environmental anxiety are driven by these population-level burdens, which are compounded by secondary stressors, lost livelihoods, protracted displacement, disrupted schooling, and recurring seasonal threat (Rataj et al., 2016; Patwary et al., 2024).
Cultural and religious meaning-making in coping. In Muslim-majority settings, including Pakistani samples, studies underscored that religious frameworks are not merely background beliefs but active, primary coping systems (Ahmed et al., 2023). Quantitative and qualitative studies show that salat (ritual prayer), Quranic recitation, dua, and mosque-based rituals provide emotional regulation, communal validation, and practical coordination of aid in crisis (Mahmood et al., 2021; Abu-Ras et al., 2024). Importantly, however, religious coping can be double-edged: while ritual and communal supplication frequently reduce subjective distress, persistent symptoms are sometimes reinterpreted as evidence of weak faith (kamzor iman), which can intensify shame and deter help-seeking (Khan et al., 2023; Mahmood et al., 2021). This finding has been reported across recent Pakistani studies and suggests that interventions must negotiate theological meanings rather than dismiss them (Fang & Mushtaque, 2024).
Emotional regulation and gendered family roles. Cross-cultural emotion-regulation research indicates that collectivist contexts favor suppression and role-centered strategies to preserve family stability and social standing (De Leersnyder et al., 2013). In Pakistan this dynamic is gendered: masculinities emphasize stoicism and provider identity, so men often conceal vulnerability while experiencing intense self-blame when livelihoods collapse; women, though more permitted to express distress within female networks, typically shoulder disproportionate emotional labour, managing children, caring responsibilities and household recovery (Ali et al., 2015; Nöthling et al., 2024). Complementing these patterns, recent Pakistan-based work shows that familial support and community leadership meaningfully buffer women's psychological distress and sustain functioning after crises, while studies of emotional experiences link interpersonal stress to cognitive distortions that perpetuate

dysregulation (Sulaiman et al., 2025). Organizational and mortality-salience research further suggests that leader coping and perceived threat shape collective resilience and recovery priorities in post-disaster settings (Dur et al., 2025; Javed et al., 2025). Recent flood-focused qualitative and mixed-methods studies from Pakistan and neighboring South Asian settings show that these role-based regulations shape symptom expression, delay formal help-seeking, and increase reliance on informal supports (Khan et al., 2023; Ahmad et al., 2025). Together, these findings indicate that emotion regulation after floods is embedded in relational roles and local leadership practices, with important implications for where and how psychosocial support is delivered (Mushtaque et al., 2021).

Barriers to formal help-seeking and service gaps. The intersection of poverty, stigma, gender constraints, and lack of culturally adapted services explains persistently low utilization of formal mental-health care in flood-affected Pakistani communities (Dayani et al., 2024; Chibanda et al., 2016). Financial precarity after floods makes healthcare literally unaffordable, while biradari reputation concerns and fears about children's marriage prospects amplify social costs of psychiatric labels (Munawar et al., 2020; Dayani et al., 2024). Recent scholarship therefore advocates for community-based, faith-integrated models, training mosque leaders, lay volunteers, and primary-care workers in psychological first aid and culturally concordant interventions, as pragmatic, acceptable pathways to scale in resource-constrained, flood-prone settings (Abu-Ras et al., 2024; Khan et al., 2023).

Synthesis and gap. Taken together, the literature establishes that floods in Pakistan cause substantial, often chronic mental-health burden; that religious and collective practices are central to meaning-making and coping; and that structural barriers severely limit formal care access (Sansakorn et al., 2024). What remains underexplored in the peer-reviewed literature is an integrated, participant-centered model that maps how acute trauma responses, chronic environmental anxiety, culturally shaped emotion-regulation, and community-level coping coalesce after recurrent floods. The present reflexive thematic analysis addresses this gap by privileging survivors' idioms of distress and by linking micro-level lived experience to macro-level constraints and resources.

METHODOLOGY

Research Design and Philosophical Approach

This qualitative study employed Reflexive Thematic Analysis (Braun & Clarke, 2022) to explore the lived experiences of anxiety and emotional regulation among flood-affected communities in Pakistan. Reflexive thematic analysis was selected for its flexibility in capturing culturally-situated meanings and its alignment with an interpretivist epistemology that recognizes knowledge as co-constructed between researchers and participants. This approach was particularly suited to exploring how Pakistani cultural values, Islamic principles, and local socioeconomic realities shaped participants' understanding and management of post-disaster psychological distress. The study was conducted in rural and semi-urban communities across Sindh and Punjab provinces following the 2025 monsoon floods, with interviews taking place approximately one month post-disaster during July-August 2025.

Participants and Sampling

A total of fifteen participants were selected purposively through communities in flood-affected areas to make the sample diverse in terms of gender, age, occupation, and geographic area. The sample was composed of eight women and seven men, aged 29-56 (41.3 years on average), who had a diverse occupational group: housewives, farmers, teachers, shopkeepers, health workers, construction workers, small business owners, and widows. They were identified using community gatekeepers such as village elders, religious leaders, or local health workers who made first contacts and guaranteed the credibility of the research team. The inclusion criteria were: the participants had to be above 18 years of age, live in flood-prone regions, and have emotional stories to share. The exclusion criteria were the presence of active psychosis or severe cognitive impairment to provide informed consent. To ensure confidentiality and still have the demographic background in context of interpretation, each respondent was given a unique identifier in the format P[Participant Number]-[Age], i.e., P03-34 to the 34-year-old participant (see Table 1).

Table 1: Participant Demographics

Participant ID	Gender	Age	Occupation	Location
P03	Female	34	Housewife	Sindh
P08	Male	52	Farmer	Punjab
P11	Female	41	Teacher	Sindh
P05	Male	38	Shopkeeper	Punjab
P12	Male	48	Former Landowner	Punjab
P04	Male	42	Construction Worker	Punjab
P15	Male	44	Tractor Driver	Punjab
P01	Male	35	Small Business Owner	Sindh
P09	Male	51	Community Health Worker	Sindh
P14	Female	45	Midwife	Sindh
P07	Female	56	Widow	Punjab
P06	Female	37	Housewife	Sindh

P13	Female	33	School Teacher	Punjab
P02	Female	29	Health Worker	Sindh
P10	Female	39	Widow	Punjab

Cultural Considerations and Access

Because of the cultural sensitivity that is needed in the rural Pakistani settings, a number of adaptations were made towards ethically accessing and providing comfort to the participant. The interview conditions were segregated by gender and men and women were interviewed in different rooms to observe cultural practices. All interviews with female participants were conducted by a Pakistani woman who speaks Urdu and Punjabi, who discusses the issue of purdah (modesty) that would have prevented the participation had the interviews been conducted by men. The timing of the interviews allowed prayer time (namaz) to show respect towards the religious requirements of the participants and not to interfere with their daily spiritual traditions that most participants cited as way of coping with the situation. Access to the community was also consulted by community gatekeepers especially the village elders and the mosque imams to make sure that the research was culturally fit and that it was perceived as an addition to society rather than an extraction.

Data Collection Procedures

The semi-structured in-depth interviews were to be carried out in the language of preference of the participants who could be either Urdu, Punjabi or Sindhi and the majority of the interviews were going to be in a mix of languages as is natural in the multilingual Pakistani setting. Participants were given limited options on interview locations so as to maximize their comfort and privacy, such as community centers, Mosque committee rooms, post school hours in schools, health facilities and the homes of participants. Open ended questions were created in an interview guide on the flood experiences of the participants, their current emotional states, coping strategies, help seeking behavior and cultural variables which affect the responses were created. The guide was tested using two individuals and was refined accordingly so as to have been culturally appropriate and understandable. The interviews were between 48 and 71 minutes with the average time at 58 minutes. All interviews were audio recorded by express informed consent and extensive field notes were made, which captured non-verbal expressions, contextual observations and interviewer thoughts. The lead interviewer kept a reflexive journal during the data collection process that recorded her emotional reactions, assumptions and the dynamics of every interview encounter.

Translation and Cultural Interpretation

Since the data collection exercise was multilingual in nature, strict translation processes were necessary to maintain meaning. Transcription was done in original languages of all the interviews and then translated to English. Bilingual Pakistani researchers who had a cultural background and are more aware of the culture did the translation and kept Urdu and Punjabi and Sindhi terms where direct English translation is not culturally sensitive, e.g., sabr (patient endurance), tawakkul (trust in Allah), and biradari (kinship network). Back-translation verification was done on 20 percent of random sampled interviews in which English versions were independently translated to back to Urdu and were compared with the originals to determine the fidelity. During translation, cultural consultation was carried out, whereby, Pakistani cultural specialists went through the translation to review the translations to contextualize idioms, religious allusions, and expressions of emotions to suit the international community without losing the actual voices of those participating.

Reflexive Thematic Analysis Process

The reflexive thematic analysis method of Braun and Clarke (2022), which includes six phases, was used to analyze the data. Phase one was related to familiarization, when transcripts written in original languages and English translation were read repeatedly, audio-recordings were listened to, and patterns and culturally important expressions were initially noted. Phase two involved systematic semantic and latent coding but was culturally sensitive with an eye to both overt content and underlying cultural suppositions in the stories of the participants. Urdu terms and terms that have cultural connotations were given special consideration and as a result, 69 different codes were given out in 15 interviews. The third phase entailed the creation of candidate themes through code grouping based on similar meanings, which are based on Pakistani culture and Islamic principles. The differences between collectivist and individualist cultural patterns were considered in the development of the themes. Phase four involved theme reviewing internal consistency within a theme and external dissimilarity between themes with verification on original transcripts of the source languages. Themes had to be checked through cultural coherence with the Pakistani research members to make sure that the themes were related to local realities. Phase five was about theme definition and naming, and the bilingual naming (English and Urdu) retained the originality of the cultures. Each theme and sub-theme had clear operational definitions. Phase six involved the writing of the analysis that included representative extracts, cultural analysis, reflexivity of the positionality of the researcher, and incorporation into the literature of disaster mental health in Muslim contexts (see Figure 1).

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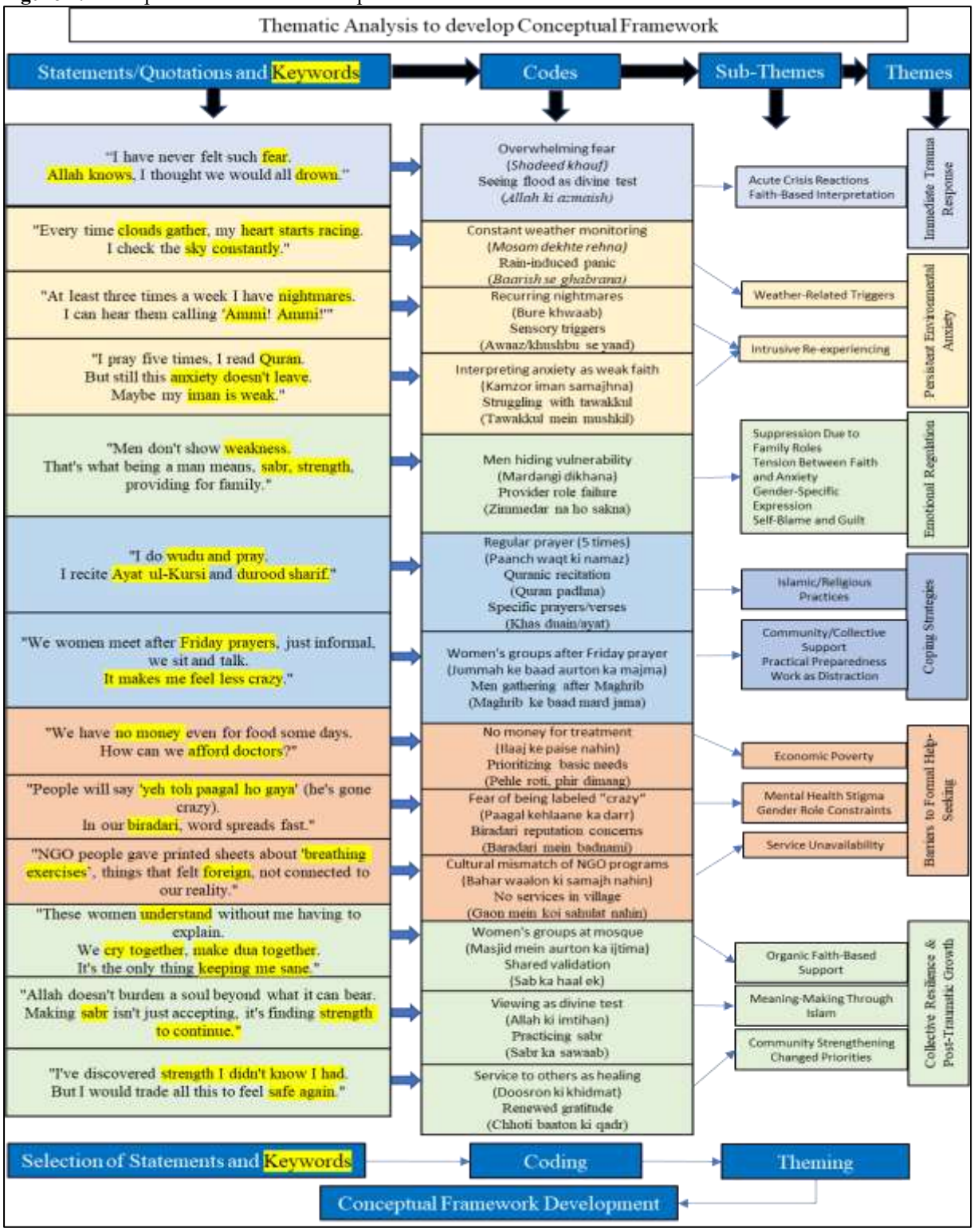
Figure 1: Conceptual Framework Development



Researcher Positionality and Reflexivity

The research team consisted of both Pakistani and international researchers and they acted as a complementary insiders and outsiders. The Pakistani Muslim identity of the lead interviewer, gender, and the ability to speak and understand local languages helped the interviewer to establish rapport and intercultural understanding especially with the female participants who would not have revealed sensitive information to the male and foreign interviewer. Her urban, educated background, however, put her in a different position as compared to the rural participants, and she needed to continue with reflexivity regarding the power relationship and assumptions. Reflexive journaling was the record of how the researcher felt about the trauma story of the participants, which led her to believe that the emotions she felt at times impacted her data collection and interpretation, and at times her progressive urban values clashed with the traditional rural gender norms as she was doing the field work.

Ethical Considerations

Before fieldwork, ethical approval was sought about institutional review boards. Informed consent was obtained in the native language, and verbal consent was accepted among the participants who had low literacy rates. This was reported with confidentiality by use of pseudonymization and geographic anonymization. Because there is scanty mental health infrastructure in rural Pakistan, the research team worked with local health workers to get referral details of participants who needed emotional support, but their availability was realized to be severely limited. There were community feedback sessions that followed the analysis phase, where the findings were presented, and results confirmed with community members and leaders.

RESULTS

Table 2: Code Distribution Across Themes (n=15 participants)

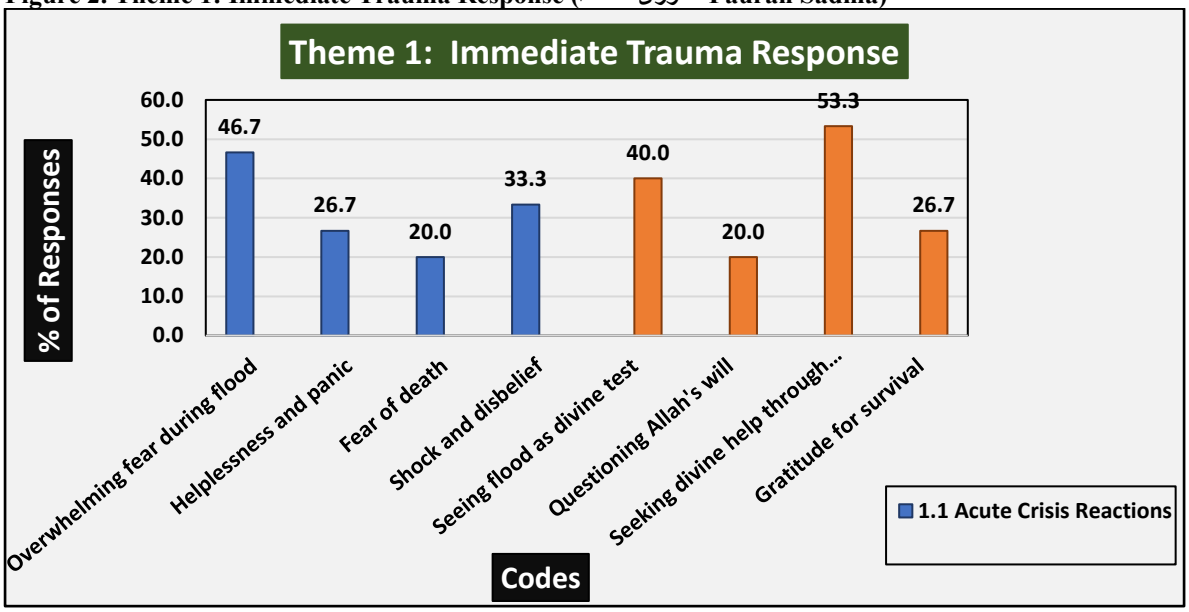
Main Theme	Sub-theme	Code Count	% of Total
1. Immediate Trauma Response (فوری صدمہ)	1.1 Acute Crisis Reactions	4	5.8%
	1.2 Faith-Based Interpretation	4	5.8%
	Sub-total	8	11.6%
2. Persistent Environmental Anxiety (موسم کی پریشانی)	2.1 Weather-Related Triggers	5	7.2%
	2.2 Intrusive Re-experiencing	4	5.8%
	Sub-total	9	13.0%
3. Emotional Regulation (جذباتی کنٹرول)	3.1 Suppression Due to Family Roles	4	5.8%
	3.2 Tension Between Faith and Anxiety	4	5.8%
	3.3 Gender-Specific Expression	4	5.8%
	3.4 Self-Blame and Guilt	3	4.3%
	Sub-total	15	21.7%
4. Coping Strategies (مقابلہ کرنے کی حکمتِ عملیاں)	4.1 Islamic/Religious Practices	5	7.2%
	4.2 Community/Collective Support	4	5.8%
	4.3 Practical Preparedness	4	5.8%
	4.4 Work as Distraction	3	4.3%
	Sub-total	16	23.2%
5. Barriers to Formal Help-Seeking (مدد کی رکاوٹیں)	5.1 Economic Poverty	4	5.8%
	5.2 Mental Health Stigma	5	7.2%
	5.3 Gender Role Constraints	4	5.8%
	5.4 Service Unavailability	3	4.3%
	Sub-total	16	23.2%
6. Collective Resilience & Post-Traumatic Growth (مل کر مضبوط ہونا)	6.1 Organic Faith-Based Support	4	5.8%
	6.2 Meaning-Making Through Islam	4	5.8%
	6.3 Community Strengthening	4	5.8%
	6.4 Changed Priorities	4	5.8%
	Sub-total	16	23.2%
Total		**69**	**100%**

Note: Code count represents distinct codes identified within each sub-theme. Percentages calculated based on total of 69 codes across all themes. Multiple participants may contribute to the same code.

It has been indicated in Table 2 that the total percentage of codes generated in the analysis as of 15 participants is 69, the highest proportion of which was occupied by coping and systemic themes: Coping Strategies, Barriers to Formal Help-Seeking, and Collective Resilience & Post-Traumatic Growth had 16 codes (23.2% each), and the Emotional Regulation had 15 (21.7%). Immediate Trauma Response (8 codes, 11.6%) and Persistent Environmental Anxiety (9 codes, 13.0%) were proportionally smaller but nonetheless important. Overall, the

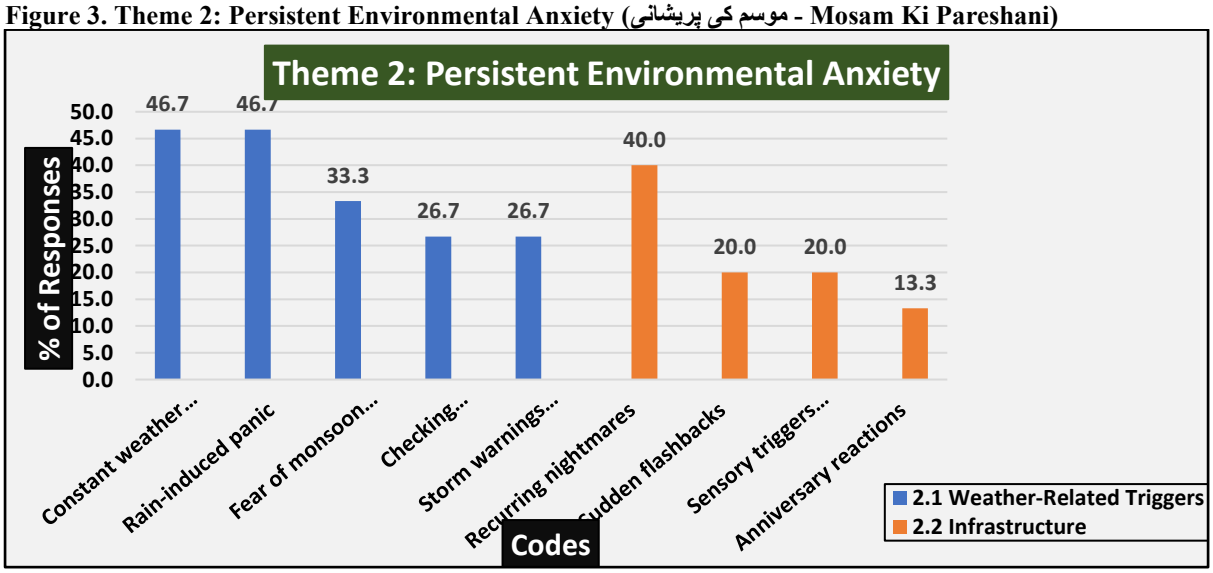
distribution indicates that participants' narratives were not only about momentary fear and re-experiencing but were heavily oriented toward culturally-embedded responses (religious practice and community support), the social/structural obstacles to formal care, and the interpersonal/gendered processes of emotional regulation, pointing to both the resilience resources and the systemic barriers shaping recovery.

Figure 2. Theme 1: Immediate Trauma Response (فوری صدمہ - Fauran Sadma)



In Figure 2, this theme describes participants' immediate psychological and faith-based responses during and shortly after the flood, where overwhelming fear, helplessness and shock co-occurred with instant religious meaning-making and supplication. As one participant captured the simultaneity of terror and prayer: "It was Fajr time, before dawn. My husband woke me saying water was coming into the courtyard. By the time we got our children and went outside, the water was already up to our knees. [pause] I have never felt such fear. Allah knows, I thought we would all drown." (P03-34) The most frequent codes in this theme were overwhelming fear during the flood (shadeed khauf; 7 instances), shock and disbelief (hairat/yaqeen na hona; 5), helplessness and panic (bechaingi/ghabra jaana; 4) and fear of death (maut ka darr; 3); on the faith side, seeing the flood as a divine test (Allah ki azmaish; 6), seeking divine help through prayer (dua maangna; 8), questioning Allah's will (Allah ki marzi par sawal; 3) and gratitude for survival (bach jaane ki shukr; 4) were prominent, reflecting how immediate survival responses were interpreted and regulated through an Islamic framework.

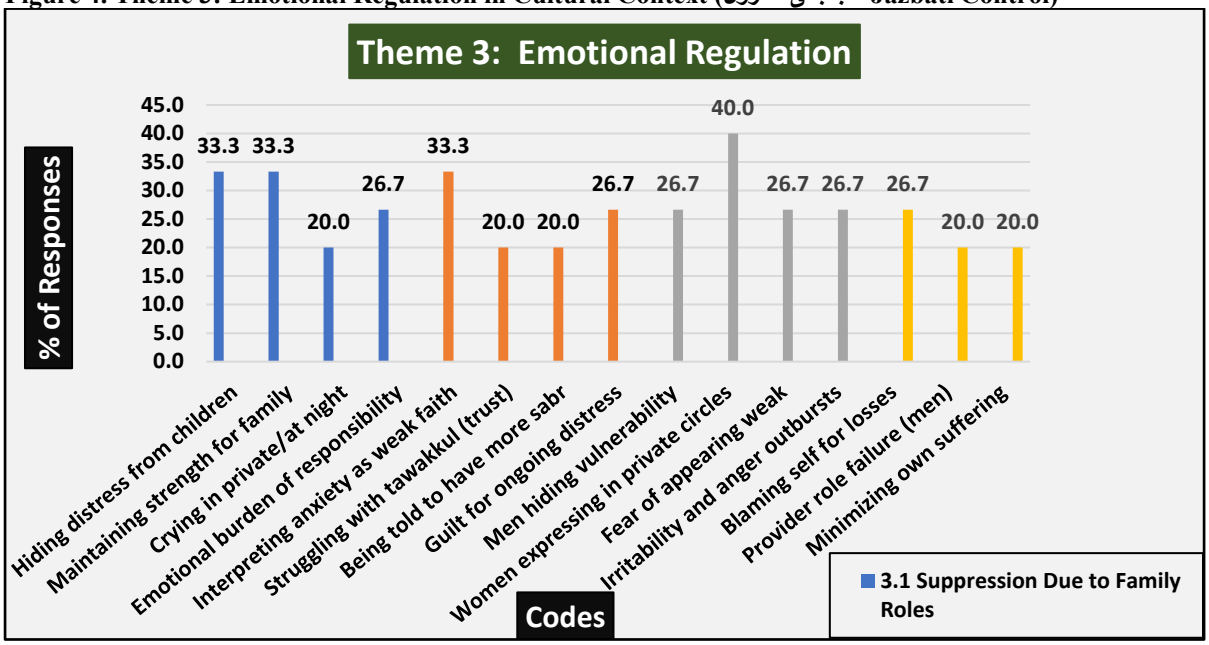
Figure 3. Theme 2: Persistent Environmental Anxiety (موسم کی پریشانی - Mosam Ki Pareshani)



In Figure 3, this theme captures enduring hypervigilance and trauma re-experiencing in response to weather-related cues, such that ordinary environmental signals (rain, clouds, storm warnings) became conditioned triggers for anxiety and physiological arousal. One participant described this ongoing vigilance and its embodied effects: "Now whenever clouds gather, mera dil dharakne lagta hai (my heart starts pounding). I check with anyone who has mobile, 'mosam kaisa hai?' (what's the weather?). My husband says I should have more tawakkul (trust in Allah), but this fear doesn't leave me." (P11-41) Key codes driving this theme included constant weather monitoring (mosam dekhte rehna; 7), rain-induced panic (baarish se ghabrana; 7), fear of the monsoon season

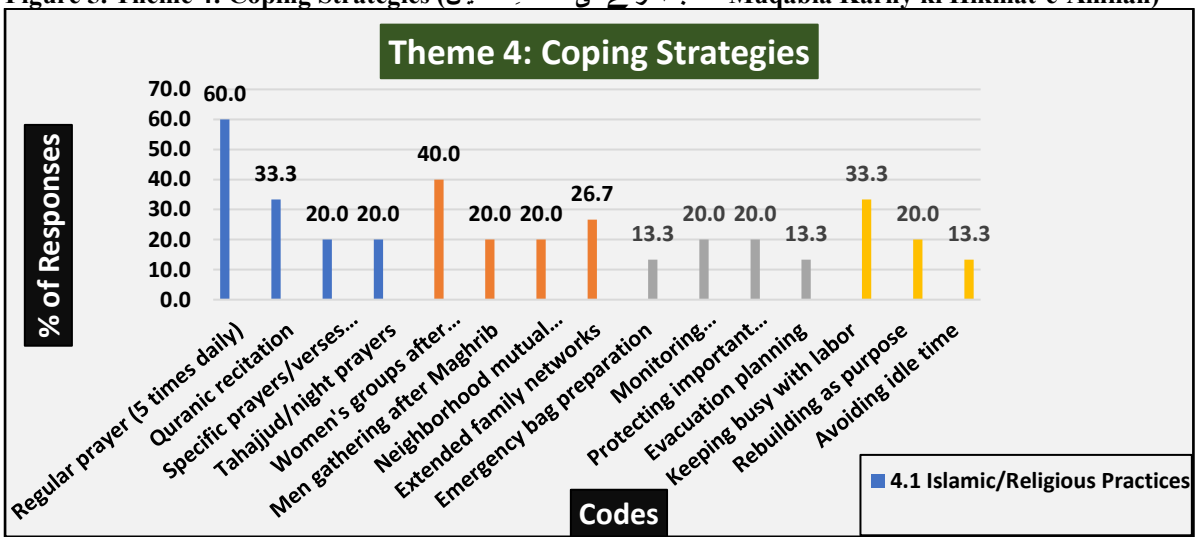
(barsaat ka mausam darr; 5), checking drainage and water channels (nali check karna; 4) and storm warnings causing distress (khabardar se pareshani; 4); intrusive re-experiencing was also frequent with recurring nightmares (bure khwaab; 6), sudden flashbacks (yaad aa jana achanak; 3), sensory triggers (sounds/smells; 3) and occasional anniversary reactions (2), indicating a shift from acute threat to chronic environmental anxiety.

Figure 4. Theme 3: Emotional Regulation in Cultural Context (جذباتی کنٹرول - Jazbati Control)



In Figure 4, this theme explains how emotional distress is managed within family roles, gender norms and religious expectations, producing patterns of suppression, private expression and moralized self-evaluation. Participants described hiding distress to shield children and sustain household functioning, while simultaneously questioning whether persistent anxiety signalled weak faith; one mother explained the pressure to remain composed: "I have four children, ages 4 to 14. My husband works in the city now, comes home only on weekends. So I'm managing everything, the children, the house, trying to rebuild our lives. I can't fall apart. Who will take care of them?" (P06-37) Key codes include hiding distress from children (bachon se chhupana; 5), maintaining strength for family (ghar walon ke liye mazboot rehna; 5), crying in private (chhupp kar rona; 3) and emotional burden of responsibility (zimmedari ka bojh; 4); codes that link faith and anxiety were common (interpreting anxiety as weak faith, kamzor iman; 5; struggling with tawakkul; 3; being told to have more sabr; 3; guilt for ongoing distress; 4); gendered patterns were evident (men hiding vulnerability; 4; women expressing in private circles; 6; fear of appearing weak; 4; irritability/anger outbursts; 4) and self-blame/provider-role failure featured repeatedly (apne aap ko kosna; 4; zimmedar na ho sakna; 3), showing how cultural expectations shape regulation and limit visible help-seeking.

Figure 5. Theme 4: Coping Strategies (مقابلہ کرنے کی حکمتِ عملیاں- Muqabla Karny ki Hikmat-e-Amlian)



In Figure 5, this theme describes the principal, culturally legitimate strategies participants used to manage distress and regain agency: religious practices, collective support, practical preparedness and work-focused distraction. One participant summed up the calming function of ritual: "When the fear comes, I do wudu and pray two rakaat.

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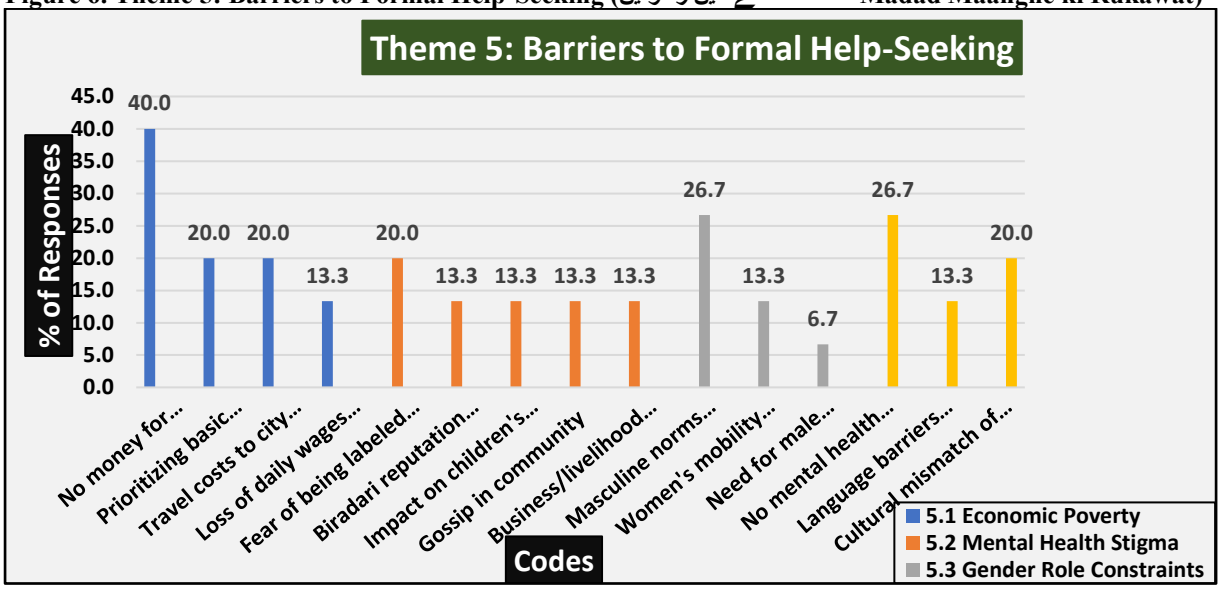
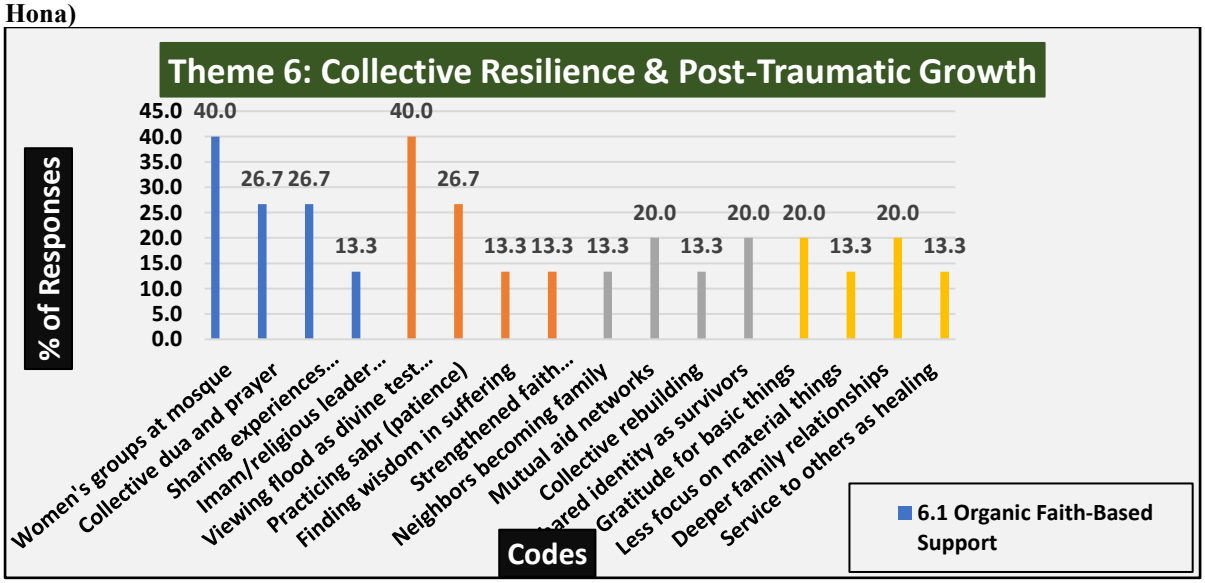
Then I recite Ayat ul-Kursi seven times. Yeh mujhe sukoon deta hai (This gives me peace). It doesn't remove all the fear, but it helps me breathe." (P05-38) The dominant codes were regular prayer (paanch waqt ki namaz; 9), Qur'anic recitation (Quran padhna; 5) and specific protective verses/du'ā (3), alongside community supports such as women's groups after Jummah (6), men's gatherings after Maghrib (3), neighborhood mutual support (3) and extended family networks (4). Practical preparedness (emergency bags; 2; drainage monitoring; 3; protecting documents; 3; evacuation planning; 2) and work as distraction (keeping busy with labor; 5; rebuilding as purpose; 3) also served to restore a sense of control and purpose.

Figure 6. Theme 5: Barriers to Formal Help-Seeking (مدد مانگنے میں رکاوٹیں - Madad Maangne ki Rukawat)



In Figure 6, this theme articulates the systemic and sociocultural obstacles that prevent people from accessing professional mental-health care, poverty, stigma, gendered mobility constraints and service gaps, making formal help impractical or socially costly. A participant explained the economic impossibility: "Where would I go? The nearest city hospital is two hours away, and we have no money for that. We're still in debt trying to rebuild. My husband is working as a laborer now, we lost our land. How can we afford doctors?" (P03-34) Prominent codes include no money for treatment (ilaaj ke paise nahin; 6), prioritizing basic needs over mental health (pehle roti, phir dimaag; 3), travel costs to city hospitals (3) and loss of daily wages for appointments (2); stigma codes, fear of being labeled "crazy" (paagal kehlaane ka darr; 3), biradari reputation concerns (2), impact on children's marriage prospects (2) and gossip (2), indicated strong reputational barriers, while gender constraints (masculine norms; 4; women's mobility restrictions; 2; need for male escort; 1) and service unavailability/cultural mismatch (no local services; 4; language barriers; 2; NGO programs not adapted; 3) explained why even willing help-seekers are often unable to obtain culturally appropriate care.

Figure 7. Theme 6: Collective Resilience & Post-Traumatic Growth (مل کر مضبوط ہونا - Mil Kar Mazboot Hona)

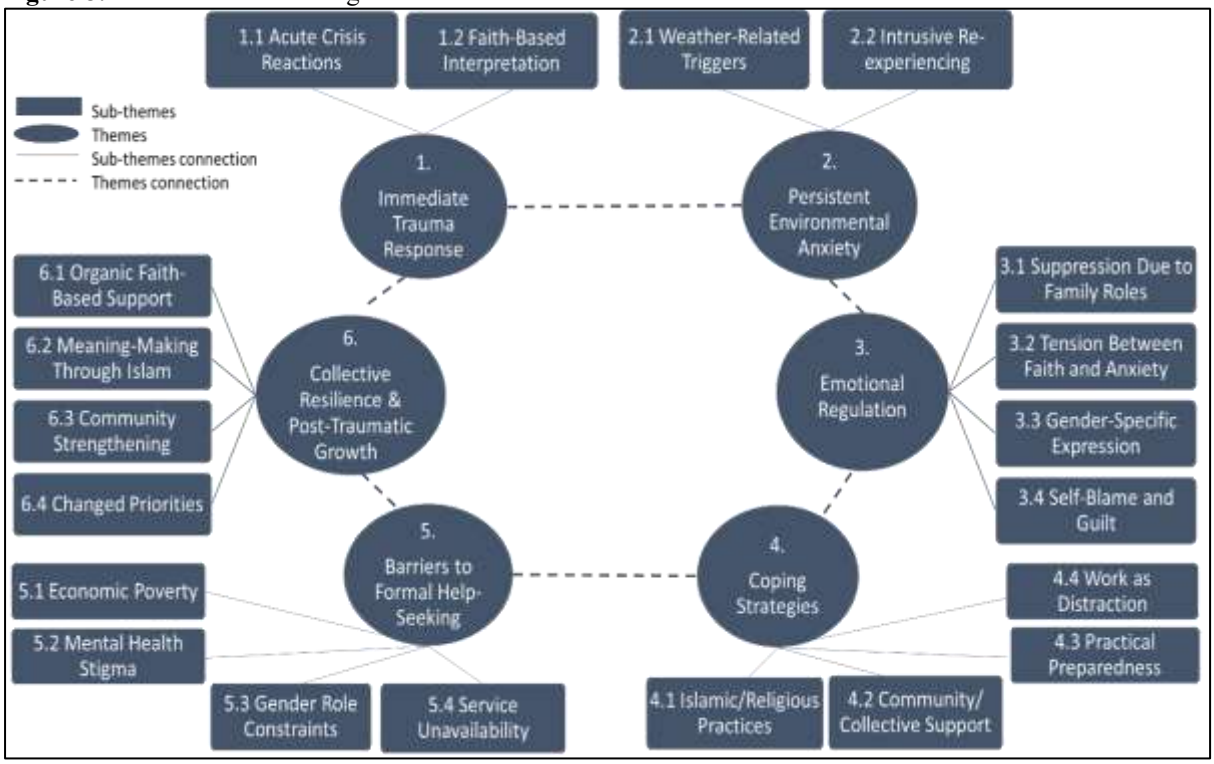


In Figure 7, this theme highlights communal, faith-anchored pathways to meaning, solidarity and growth that emerged despite substantial loss: women's mosque circles and collective dua offered validation and practical aid;

Islamic meaning-making (imtihan/sabr) reframed suffering; neighborly mutual aid and shared rebuilding strengthened social bonds; and some participants reported changed priorities and healing through service. As one woman observed, “it made me realize I wasn't going crazy. That my fear of rain wasn't overreacting, it was normal after what we went through. Hearing other women describe the same exact feelings, the same nightmares, it validated my experience. It gave me permission to not be okay yet." (P07-56)” Key codes include women's groups at mosque (Masjid mein aurton ka ijtima), n = 6, collective dua and prayer (Mil kar dua karna), n = 4, sharing experiences validates suffering (Sab ka haal ek), n = 4, imam/religious leader guidance (Imam sahib ki nasihat), n = 2; meaning-making codes (viewing flood as divine test; 6; practicing sabr; 4; finding wisdom in suffering; 2; strengthened faith; 2), community strengthening (mutual aid networks; 3; collective rebuilding; 2; shared survivor identity; 3) and changed priorities (gratitude for basics; 3; deeper family relationships; 3; service to others as healing; 2) together show resilience that is communal, spiritual and purposive rather than individualized.

Furthermore, Figure 8 shows the themes as a dynamic system: Immediate Trauma Response fuels Persistent Environmental Anxiety, while Emotional Regulation (suppression, faith, anxiety tension, gendered expression) mediates whether distress is hidden or acted on. Coping Strategies and Collective Resilience (religious practice, community support, practical action) buffer distress and enable rebuilding, whereas Barriers to Formal Help-Seeking (poverty, stigma, gender constraints, service gaps) block access to professional care and reinforce maladaptive cycles.

Figure 8: Interconnection among Sub-Themes and Themes



In Sum, participants’ accounts foregrounded culturally-embedded coping and communal resilience while revealing powerful structural and sociocultural barriers (poverty, stigma, gender constraints, service gaps) that limit formal help-seeking and shape emotional regulation post-flood.

DISCUSSION

The present study’s thematic model situates flood-related anxiety and emotional regulation within an ecological, culturally inflected process: acute threat and faith-based meaning-making precipitate chronic environmental hypervigilance, which is then filtered through gendered family roles, communal practices, and structural constraints to produce distinct patterns of coping and help-seeking (Sarfraz et al., 2022). This pattern both confirms and extends recent disaster-mental-health research by showing how the phenomenology of distress and the available buffers are co-constructed by Islamic frames, collectivist expectations, and severe resource constraints. Empirical syntheses show that disaster exposure generates substantial, sometimes persistent, rates of anxiety, depression, and post-traumatic stress (Heanoy & Brown, 2024), and cumulative exposure multiplies risks, findings that help explain why repeated monsoon floods in Pakistan produce chronic rather than transient distress among affected communities.

For instance, the linkage between Immediate Trauma Response and Persistent Environmental Anxiety observed in participants echoes learning- and stress-sensitization mechanisms documented in disaster research: acute threat experiences condition ordinary environmental cues (rain, clouds, drainage sounds) into triggers for hyperarousal and intrusive re-experiencing (Heanoy & Brown, 2024). Our data show this conditioning expressed through culturally specific idioms (e.g., “mera dil dharakne lagta hai”) and somatic complaints rather than biomedical

labels, an observation consistent with regional studies documenting high post-flood anxiety expressed in somatic and idiomatic language (Yousuf et al., 2023). The practical implication is the idea that screening and psychosocial interventions need to aim at including locally relevant descriptions of symptoms instead of bringing in clinical jargon that might not correlate with lived experience.

Equally, the intense saliency of religious meaning-making, in which the flood is interpreted as imtihan/azmaish and prayer is one of the dominant regulatory practices is an adaptive cultural logic as opposed to resignation. Religious practices offered short-term emotion-regulation resources, status quo validation, and endurance scripts; this overall supports the emerging evidence on how rituals and mosque-based networks grounded in faith can serve as an effective, acceptable community-based mental-health tool when carefully combined with psychosocial support (Abu-Ras et al., 2024). But in the same way as our analysis also records the paradox seen elsewhere, the continuance of symptoms despite ritual participation can be understood as poor faith, generating secondary spiritual distress which exacerbates psychological distress and discourages its revelation. Interventions should therefore be done with respect to religious coping taking into consideration the moralization of the symptoms in such a way that help should not be blocked by faith.

Moreover, group tendencies of emotional regulation were very strong in collectivist settings in influencing disclosure and help-seeking. There was widespread suppression in the interests of the children and to uphold izzat (family honour); this follows cross-cultural patterns in which collectivist societies prefer suppressive and relation-focused regulation methods, which can hold society together but also can generate high levels of internal distress when stressors are chronic (Song et al., 2024; Pugh et al., 2022). These dynamics were intensified by gendered norms: male norms of providers created high self-blame and unwillingness to display vulnerability, and women tended to confide in one of their female groups but experienced barriers to accessing formal care due to mobility and logistical factors. This gendered emotional labour is the cornerstone of a household, as well as the obfuscation of need, the reason why emotional burden is concentrated in family roles and not clinical manifestations (Sawangchai et al., 2022).

Also, structural and social barriers to formal help-seeking were present in this sample: extreme poverty, opportunity and travel costs, reputational stigma, and the lack of culturally sensitive services made the clinic-based care unhelpful to many participants. It has been repeated in national surveys, indicating nationwide attitudinal and practical barriers to psychological treatment in Pakistan (Husain, 2020) and highlights the policy necessity: mental-health response can not be an add-on clinic located in urban centres; it has to be decentrally located, low-cost, and adaptable to local language and religious repertoires.

Moreover, the study's identification of community-level buffers, women's mosque circles, collective dua, and neighbor mutual aid points to scalable intervention levers. Faith-based and community networks already serve validation, psychoeducation, and basic social support; partnering with imams, female community leaders, and local health workers to deliver brief psychological first aid, normalize post-traumatic reactions, and create referral pathways could reduce stigma while leveraging trusted platforms (Abu-Ras et al., 2024). Evidence reviews of climate-related mental-health responses also argue for integrated approaches that combine material recovery with psychosocial support to prevent chronicity (Heanoy & Brown, 2024).

Blending transactional stress-coping and ecological systems perspectives (Bronfenbrenner, 1979) remains valuable but requires adaptation for contexts where religion and collectivism are primary organizing principles. Our model suggests a culturally expanded transactional framework in which appraisal maps onto theological categories (suffering as test/punishment), coping resources are communal and ritualized rather than individualistic, and systems-level constraints (poverty, service gaps, gender norms) close or open pathways to recovery. This culturally situated framing aligns with broader calls in the climate-mental-health literature to move beyond Eurocentric models and to co-design interventions with communities (Sharpe & Davison, 2021).

Limitations notwithstanding (small purposive sample, short post-disaster window), the findings have actionable implications: (1) integrate culturally congruent psychosocial support into disaster response through faith and community structures; (2) prioritize mobile, low-cost outreach to overcome economic and mobility barriers; (3) include gender-sensitive programming that addresses masculine role pressures and supports women's caregiver burdens; and (4) train local providers in culturally informed psychoeducation that de-stigmatizes help-seeking without undermining religious coping.

Future research should evaluate such hybrid interventions' effectiveness in reducing intrusive re-experiencing and improving functional recovery after recurrent floods. Collectively, this study argues that effective disaster mental-health policy in Pakistan must be ecological, faith-attuned, and equity-focused, rooted in what communities already use to survive, and reshaped to reduce what prevents them from thriving.

In Conclusion, the current study demonstrates that flood-related anxiety in Pakistani communities is an ecological process shaped by acute threat, theological framing, collectivist emotion norms, gendered family roles, and severe structural constraints. Participants' accounts show that immediate trauma conditions ordinary environmental cues into chronic hypervigilance, that religious practices and communal networks are primary emotion-regulation resources, and that poverty, stigma, and service gaps systematically block access to formal care. Effective disaster mental-health responses therefore require embedding psychosocial support within trusted religious and community platforms, decentralizing services to reduce travel and cost barriers, and implementing gender-sensitive programming that addresses both masculine role pressures and women's caregiver burdens. Policymakers and practitioners should prioritize training imams, female community leaders, and lay health

workers in culturally adapted psychological first aid, while pairing psychosocial interventions with material recovery to prevent chronicity. Finally, rigorous evaluation of hybrid community-faith models is essential to confirm their impact on intrusive re-experiencing and functional recovery; scaling such models will align policy and practice with how communities already live through and recover from repeated climate calamities.

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